DOCUMENT RESUME

ED 264 216 SP 026 884

TITLE	Principles of Development of Model Health Care Programmes. Report on a WHO Meeting. (Turku, Finland, May 3-6, 1982). EURO Reports and Studies 96.
INSTITUTION	World Health Organization, Copenhagen (Denmark). Regional Office for Europe.
REPORT NO	ISBN-92-890-1262-5
PUB DATE	May 82
NOTE	49p.
PUB TYPE	Reports - Descriptive (141)
LANGUAGE	English; French; German; Russian
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Cooperative Planning; Cost Effectiveness; Foreign Countries; Government Role; *Medical Services; *Program Development; *Public Health
IDENTIFIERS	*Model Health Care Programs

ABSTRACT

A report is given of the work of a group convened by the World Health Organization (WHO) to address the issues related to the development of Model Health Care Programs (MHCPs), and to apply the principles thus identified to the case of a specific health problem--low back pain. A discussion of the principles of the development of MHCPs includes consideration of motivation for developing the program, types of program models, the content of an MHCP, and criteria for selecting health problems. The problem of low back pain is used as an example of a health issue that is responsive to the functions of an MHCP program at both local and national levels. Appended are descriptions of the Finnish model health care program project which was developed to deal with the problem of strokes. (JD)

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World Health Organization
Regional Office for Europe
Copenhagen

EURO Reports and Studies 96

Principles of development of model health care programmes

Report on a WHO meeting

Turku, Finland
3–6 May 1982

ICP/SPM 042

ISBN 92 890 1262 5

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PRINTED IN DENMARK

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INTRODUCTION

A Working Group on the Principles of the Development of Model Health Care Programmes met at the Rehabilitation Research Centre of the Social Insurance Institution in Turku, Finland, from 3 to 6 May 1982, to address issues related to the development of model health care programmes (MHCPs) and to apply the principles thus identified to the case of a specific health problem — low back pain.

Mr Jaakko Pajula, Director-General of the Social Insurance Institution, opened the meeting. He emphasized the need for a systematic assessment of the health technology needed in health care. Measures to be taken by the health care system at primary, secondary and tertiary levels, as well as those to be taken by other sectors, have to be defined. It is also necessary to determine the measures that should be taken by individuals and families in their homes. Although the concept of MHCPs is new, Finland has considerable experience in developing such programmes and their usefulness has been demonstrated. They support the development and management of health technology and health services that respond to the real health needs of the population and are socially acceptable, safe and cost-effective.

Mrs H. Paatero conveyed the greetings of the National Board of Health, which is one of the partners in the development of MHCPs in Finland. Dr Arpo Aromaa was elected Chairman and Professor Sven-Olof Isacsson Rapporteur. The list of participants is given in Annex 4.

Scope and purpose

An earlier WHO Workshop on the Cost-Effectiveness of Recommending Standard Patterns of Long-Term Care[a] addressed the question: Is it

[a] WHO document ICP/RPD 802.

worth while (in terms of cost-effectiveness) to recommend standard patterns of care? Using the deliberations and recommendations of that Workshop as its point of departure, the present Working Group focused on the question: How should MHCPs be developed and how can they be implemented? The Working Group brought together clinicians, people with experience in the development of MHCPs, administrators of health care institutions and national health authorities, and members of the research community, to discuss such issues as the motivation for developing MHCPs, the uses of such programmes, and national and local mechanisms for developing and implementing them. While the Working Group constituted a major step towards a much deeper clinical involvement for WHO than in the past, it was not the purpose to study the specific medical contents or scientific validity of the procedures and techniques included in the MHCPs.

The Working Group served two purposes. First it addressed itself to the above broad issues related to the development of MHCPs. Then it applied the principles identified during the first phase to the case of a specific health problem, low back pain, for which a number of collaborating centres have agreed to develop a care programme.

This report is expected to be of value to national health authorities considering setting up a planning mechanism for the systematic development of MHCPs, to clinicians and health care administrators in the process of developing specific local programmes, to educators responsible for training health personnel to use such programmes, and to the research community interested in health services research aimed at making health services more effective and cost-efficient.

PRINCIPLES OF THE DEVELOPMENT OF MHCPs

Motivation

Disease patterns are changing. In the aging population, chronic diseases are frequent. There are more and more providers of health care. Diagnostic, therapeutic and rehabilitative measures are becoming more complex as knowledge increases. What should be discarded and what should remain? It is here that health care programmes may play a role.

The most important motivation for a health care programme for a defined health problem should be the improvement of the quality of care. To give care at the right time based on the best scientific knowledge and experience is the main purpose of health care programmes. Another motivation for health care programmes is to provide high quality care at lower

cost, if possible, by making more rational use of available resources. By giving the optimal level of care and by eliminating unnecessary diagnostic, curative and rehabilitative procedures, the care given may also become more cost-effective and safer. Waste, overlapping work, wrong investments, the inappropriate division of labour between institutions, examinations and treatment with marginal or no utility, and the irrational use of health services may be reduced by the programmes. A standardization of the treatment process is also a prerequisite for estimating the necessary resources for and costs of treating various diseases for national and regional plans.

In brief, it may be said that a care programme should aim to provide a better:

— balance between medical and social care based on a view of the patient and his environment as an integrated whole;

— allocation of labour and coordination between different care levels and care forms as well as between different categories of personnel;

— interchange of information between research, training and medical care;

— basis for policy decisions and planning;

— basis for expanded and more readable information for better self-care.

A care programme, if accepted, may also serve as a basis for increased interest in research in the field. It may help indicate where it is possible to provide care at another more optimal level, for instance in primary health care.

Although no formal evaluation, based on hard data, has been carried out of the extent to which the programmes have actually achieved their expected objectives, there are good reasons for believing that health care programmes for at least some important disorders can improve the quality of care and make it more cost-effective.

Types of model

Guidelines for health care practice exist in many countries. As reported at the Workshop on the Cost-Effectiveness of Recommending Standard Patterns of Long-Term Care, there are a wide variety of guidelines.

1. *Policy documents issued by central or local governments.* Examples can be found in the United Kingdom.

2. *Methodological letters.* These are essentially circulars dealing with aspects of treatment methods, issued by national institutes in eastern European countries.

3. *Audit and peer review schemes.* The emphasis in this approach is on developing a system of retrospective review (usually by medical peers) of the operation of institutions and activities of medical practitioners, rather than on standards *per se.* An audit does, however, presume explicit or implicit standards agreed upon in advance.

4. *Physician protocols or algorithms.* These are suggested procedures, often for diagnosis, for use predominantly by junior physicians or non-medical staff. They are common in a number of countries.

5. *Model health care programmes.* Examples of such programmes exist mainly in Scandinavia (Finland and Sweden). They can be defined as documented sets of guidelines on how to manage a patient with a given problem in the best possible manner with available resources. They are the main focus of this report.

Some experiences gained in developing MHCPs in Finland are reported in Annex 1. Much can be learned from such experiences when planning one's own MHCP. The general features of a programme for stroke are briefly described in Annex 2. Other examples can be found in the report of the WHO Working Group on Cost-Effectiveness of Recommending Standard Patterns of Long-Term Care.

Content

An MHCP is a documented local agreement on how the available medical and other services can best be offered to people with a defined risk of disease or with the symptoms or diseases themselves. It is a written action programme for the prevention of disease and the examination, referral, treatment and follow-up of affected people.

But a care programme does not merely specify courses of action for diagnosis and treatment. It also allocates functions to various categories of personnel in inpatient and outpatient care services. In other words, the care programme specifies the organization and adequate level of care.

A care programme is not intended to standardize the medical treatment of the individual patient, whose overall problem pattern will rarely coincide with a standard pattern. The patient's total situation must be considered in determining the treatment in each individual case. The care programme merely lays down the framework, which is adapted to the

patient's condition and changes therein that may be the result of medical, psychological or social factors.

The contents of a written care programme may vary, but as a general recommendation based on experiences from different countries, they may include:

— a brief review of the etiology, prevalence and incidence of the condition;

— the characteristics, symptomatology and complications of the condition;

— the social consequences of the condition;

— the available preventive and control measures;

— the diagnostic and therapeutic measures;

— the organization and level of care, including nursing care, community care, home care and so on.

It is impossible to specify the contents of each individual programme in advance. They will depend on factors such as existing knowledge about the particular disease, the local medical care organization, the available resources, etc.

It is important that the care programme is not limited to medical care alone, but also includes nursing care, patient information and social services when appropriate. This means that when developing care programmes, one must be able to draw on knowledge and experiences gained within a range of different fields. A care programme will have to be developed and supported by the personnel who will be affected by it in order for it to function in practice. A care programme produced by a few experts who are not in constant touch with its actual users will be regarded merely as another directive from above. Involvement, loyalty and motivation are naturally best among people who have participated in the development of the programme. Such broad-based participation delays the development of a care programme, but is necessary to ensure that the concerned physicians, nurses, etc. understand and accept the programme.

It may be difficult to reach agreement on a universal care programme. The realistic alternative is to establish care programmes within regions and institutions taking into account the existing structure and resources.

Criteria for selecting health problems

A health problem may be selected for different reasons as the subject of an MHCP. The cost argument should not be the leading one. Based on experiences from different countries, the selection criteria may look as follows:

- the problem (disease, symptom, risk) is of high prevalence and demands a substantial part of available resources;
- several levels of care and different categories of health personnel are involved;
- the quality of care varies greatly;
- a care programme would be able to improve the quality of care or the use of resources in a favourable way.

Sometimes it may be of interest to select a problem that is not very big at all levels of care but provides a basis for testing an idea. Hypertension is not a big problem in hospital care, but it is an excellent problem to apply an MHCP to. It illustrates the role of prevention, screening, coordination of different care levels, nursing, ambulatory care, patient education, etc. in the care of a patient. Another problem that fulfils the criteria mentioned above is low back pain.

LOW BACK PAIN AS AN EXAMPLE

The following sections dealing with low back pain are intended to illustrate the kind of information that could be given and the kind of considerations that could be taken into account in an actual care programme. Most of the ideas are applicable to other conditions for which MHCPs may be developed.

Low back pain fulfils the criteria for an MHCP. Most individuals have sometimes had pain in the back and usually this pain is located in the lower part of the back.

Sometimes, if the pain lasts only a short time, local muscle inflammation may explain the pain. In the older age groups, especially among women, osteoporosis may explain chronic low back pain.

In most cases, the symptoms disappear within a few days to a few weeks. According to reported data from some countries, about 4% of the

population between the ages of 20 and 60 years have had at least one long-lasting period of low back pain causing them to stay home from work.

The first task in starting to develop a model health care programme for a condition such as low back pain is to agree on an unequivocal definition. In this context, low back pain could be defined as:

(*a*) low back pain, where the pain may be less or more intense and may even irradiate to the gluteal region but not to the leg (lumbago, lumbalgia, etc. without root involvement); or

(*b*) sciatica with more or less pain in the back and irradiation to the leg at the same time; if the irradiation follows a certain nerve segment it is known as rhizopathia (nerve root involvement).

Other diagnoses such as Bechterew's disease, myeloma, spondylitis, fractures, ischaemia, etc. are not classified as "low back pain" or "sciatica". These diagnoses are not the target for this MHCP but should be excluded case by case before applying the MHCP.

To plan a care programme, one needs to know the size and nature of the health problem, its determinants and its social and economic consequences. Epidemiological data on the prevalence, incidence and distribution of the problem in the population, coupled with information on the current use of health services for the problem, enable us to estimate the amount and type of services and other measures required. An evaluation of the services already provided in terms of met and unmet needs is helpful when one is looking for priorities — priority problems or priority groups — in the implementation of various elements of a health care programme.

Data on the epidemiology of low back pain and its consequences may differ according to the classification and other methods used in the analysis. The Mini-Finland Study is an example of how epidemiological data can be gathered. Information on the findings of the study are given in Annex 3.

There is a tremendous lack of knowledge about the causes of back pain and effective ways of modifying it. The ideal method for controlling back pain is primary prevention. Unfortunately, there is no scientific evidence for the value of different prophylactic measures. More research is needed.

There appears to be considerable variation in the availability of various forms of therapy. Many doctors appear not to use the most appropriate methods of examination for patients with back pain. Again more research is needed on current treatment patterns.

In summary, low back pain is a very common health problem, resulting in considerable use of the health services. Methods of prevention, diagnosis, treatment and follow-up vary greatly. This justifies a programme aimed at rationalizing the use of resources. To reach this goal, we also need methods of prevention, treatment and rehabilitation of proven value. Epidemiological data as well as evaluative studies and trials are thus an essential basis for the development of care programmes for back disorders.

What should be considered when developing an MHCP

What should be considered when developing an MHCP for low back pain in any country or health care system? The following ten points seem to provide a useful framework to start with.

Prerequisites and background knowledge

The first thing is to decide whether the selected health problem really is important enough to spend resources on. The first question therefore will be: Is low back pain such a great health problem that we need better care for people suffering from it? The person raising this question can be a general practitioner, a specialist in orthopaedics or occupational health, a physiotherapist, a nurse, an administrator, a politician, or a patient.

If the answer is *no,* try to define a more important health problem and use the ideas presented in this report. If the answer is *yes,* think about how low back pain is handled today, within and outside the health care system. Who else might be interested in creating an MHCP for low back pain?

From the beginning, try to involve a leading research group with a broad interest in the field. The group developing an MHCP should have close contacts with the scientific community.

Define the terminology and consult others in doing so. What is low back pain? What are we going to concentrate on? Collect data regarding low back pain. Try to get information on the prevalence and incidence of low back pain in the area. Of particular interest is knowledge about how, by whom and where low back pain patients are taken care of. Try to get information about how many outpatient visits and admissions to hospital are caused by low back pain. Where do people primarily seek help when they get back pain? Is this level overspecialized with regard to diagnostic equipment and possibilities for treatment?

Try to define unmet needs by assessing the amount of self-care and lay care provided. Also try to quantify the consequences of low back pain in terms of absence from work and other social problems.

During the planning phase, no concerned parties should be forgotten: physicians at different levels, physiotherapists, occupational therapists,

nurses, social workers, administrators, politicians, researchers, voluntary organizations, patients and many others should be involved.

In the beginning, the ideal is that a few people collect as many data as possible on low back pain in the region. This will supplement information from other sources such as the scientific literature, WHO reports and an analysis of the health service system. This information is needed to describe the problem to key individuals and groups. It forms a basis for discussion at the local level.

An MHCP project will also cost some money. It must be clear that the money can be raised to guarantee the running of the programme for a certain time. As a rule, costs will be higher at the beginning of a programme than later on.

Aims and objectives of the programme

The general aims of an MHCP for low back pain should be to decrease the overall incidence of low back pain, to improve the use of existing resources and to improve the quality of care for the same or, if possible, lower costs. Specific objectives could be to improve the diagnostic, treatment and rehabilitative procedures, to shorten waiting time before seeing a specialist and to stimulate cooperation between different categories of personnel.

It is important that the people who will be involved in planning and running the programme know and share the aims and objectives of the programme.

Strategies for reaching the objectives

If one of the aims is, say, to change care from inpatient or hospital outpatient clinics into care at the primary level, different strategies to reach this aim could be suggested. In the same way, different strategies to cut the waiting list, improve prevention and decrease drug treatment could be given.

It is wise to implement the programme step by step, starting from those objectives and areas that are easy to reach or widely accepted by key groups.

Preventive measures

Our knowledge about different preventive measures is limited. One of the reasons for this is lack of controlled trials. Despite this, experience tells us that we may gain something through preventive measures. When developing an MHCP for low back pain, it would be interesting to design it in such a way as to be able to evaluate a certain preventive measure.

Primary preventive measures that are of interest include activities in schools and the workplace and during leisure time. An important task is to analyse what is going on. Is there a health examination when people begin a new job? How is this examination done? What ergonomic work is there in the workplace? How is it performed and by whom? What should be preserved and what could be taken away? What could be added? Other interesting factors are the laws on safety in workplaces and in the environment. Identifying high risk workplaces and groups is also important. The programme should identify these potential preventive measures and assess their usefulness in the light of current knowledge.

Secondary prevention may include regular check-ups at school or in the workplace. Other interesting fields are self-care and "back schools", where people learn ways of coping with back pain and disability.

Diagnostic measures

An MHCP for low back pain should give comprehensive information on existing diagnostic routines and ensure that they are related to the level of care. The programme should also specify when various procedures should be used. Important elements here are medical history taking, physical examination, functional tests, X-ray, scintigraphy, CT-scanning and blood tests. Unmet needs may be revealed by special methods such as mailed questionnaires or standardized health examinations.

The side-effects of different diagnostic procedures should be given and their effectiveness, acceptability, availability and cost should be mentioned. There should also be information on who is responsible for different diagnostic procedures. Algorithms could perhaps be used to explain what should be done and by whom.

Therapeutic measures including rehabilitation

All currently used therapeutic measures should be listed, evaluated and commented on. These include such measures as weight reduction, rest, training programmes, physiotherapy, "back school", occupational therapy and drugs.

The different therapeutic measures should be related to the level of care and professional competence. Who is doing what? Why? Where? Existing criteria for admitting people to hospital and for discharging them should be given.

In this part, the social and other aspects of rehabilitation should also be mentioned. Self-care as an important therapeutic measure should also be included.

Social aspects

In many patients, both the etiology and consequences of chronic low back pain are associated with several social factors. Therefore, when developing an MHCP for low back pain, the social aspects should not be forgotten. Factors such as housing, marital status, the economy, working conditions, job satisfaction, the insurance system and the pension system may be important in explaining relapsing or long-lasting low back pain disorders. The possibility of going back to the same workplace with lighter work but the same salary is important. Alcohol may play an important role in the prognosis in many cases.

In this context, it is also important to discuss the patient/doctor relationship and the very important need to encourage professionals to think of nonclinical solutions.

Educational and research needs and other supporting measures

An MHCP for low back pain should be written in such a way that it stimulates research and should preferably have links with a research group. A review of existing research problems and results should be included in the programme. Special efforts should be made to stimulate research on the cost-effectiveness of alternative treatments.

An MHCP could be used in undergraduate education to stimulate interest in programmes in general, and in postgraduate education in the development of programmes for important health problems. The programme or part of it may also be used as an educational tool in schools or workplaces. It is important that the programmes are regularly revised to keep them up to date.

Evaluation

For most people interested in developing an MHCP, evaluation may be a difficult process. It is, therefore, very important to decide from the beginning in detail what should be evaluated, how and by whom.

For most purposes, a relatively modest evaluation will suffice. Before launching the programme, knowledge about existing procedures must be well documented. During and after the programme, such things as changes in the patterns of care, the frequency of meetings of the programme group, feedback from general practitioners, attendance at educational activities, the attitudes of patients, and the use of the programme can be recorded.

This type of evaluation is not as costly and does not need as detailed a scientific approach as a controlled trial or the testing of a certain hypothesis. It consists primarily of a description of the baseline situation and of the results of the actions taken.

A more scientific approach can be used to test hypotheses and answer different questions, such as: Does the programme shorten hospital stay for low back pain? Is one type of treatment better than another? Is a certain preventive measure worthwhile? What role does physiotherapy play in rehabilitation? It may be a good idea to try to test some hypotheses in connection with each programme. This may stimulate researchers and specialists to take a more active part in the programme.

Target groups

The target groups for whom the MHCP is intended must be clearly defined. Because low back pain concerns many different groups, as many of these groups as possible should be involved. One should try to include representatives of these groups in the planning, running and evaluation of the programme. Information on the programme should be given to all relevant groups early on even if help from, and the participation of, some of these groups will not be needed until a later stage. Depending on the focus of the programme, there may be some key target groups. Examples of target groups are back pain patients, families, consumer organizations, school teachers, trade unions, sports clubs, insurance companies, health personnel at different levels, health administrators, educators of health personnel and politicians.

When lay people are involved, it is particularly important to define clearly what can or should be done by whom and also what should not be done.

Introduction of an MHCP at the national or local level

Even the best programme may fail completely because of poor introduction or backlashes during the running of the programme. The "right" people have to write the programme and run it. There must be economic and personnel resources available to assure its implementation. Perhaps the most important prerequisite is an agreement on the medical content of the programme. This can be achieved by arranging consensus meetings for the concerned groups. Additional steps that are important in the introduction of an MHCP are as follows.

1. Send the draft to key persons and groups for criticism and discussion. Modify the programme in the light of the criticism so that it will satisfy them as far as possible. Further contacts may be valuable in some cases to discuss important aspects.

2. Invite relevant people to an introductory meeting and give them an opportunity to discuss the programme.

3. Write a final version of the programme. Be aware of writing it so that everybody understands the language and feels that they are members of a group working with, and being responsible for, the programme.

4. Visit different target groups and introduce the programme, which is now based on their own recommendations. Try to find co-workers in the different target groups who can assist you in its introduction.

5. Establish a programme or steering group responsible for the programme. This group should have regular meetings. It should be responsible not only for writing the programme, but also for educational activities, and the coordination, evaluation and revision of the programme. Members of the group must have enough time to participate in the work during all its phases.

6. Different ways of stimulating all concerned people should be discussed. For patients: better health? For nurses: more responsibility and more education? For physicians: the possibility of better evaluation of different procedures? For administrators: better use of existing resources?

7. The need for supporting services and logistics should not be underestimated: secretarial help, statisticians, epidemiologists, data processing, etc.

8. Both politicians and administrators at the local and central level should accept and endorse the programme. The programme should, of course, also be accepted by the scientific community.

Final report

Once an MHCP for low back pain has been prepared and implemented, which may take from one to five years, a final report should be written. This report should enable an evaluation and comparison of experiences gained in different settings using different programmes. Ultimately, it should improve the care of people suffering from low back pain.

Annex 1

THE FINNISH MODEL HEALTH CARE PROGRAMME PROJECT

When discussions about care programmes began in Finland, it was felt that comprehensive care programmes should be developed by groups in which the expertise in medicine, nursing, administration, etc. was well balanced. This was ensured by the initiation of a special project.

Sponsorship

To avoid the project being labelled authoritarian, the National Board of Health, as the responsible administrative unit, contacted voluntary associations that might be prepared to initiate it. The Finnish Hospital League was especially suitable and cooperative. The League represents the hospital owners in Finland, i.e. the local authorities. The resources of the League were limited and even the support that could be given by the National Board of Health was not sufficient to launch a project alone. However, a semi-official foundation, SITRA (Finnish Independence Foundation) exists for supporting development and rationalization. SITRA became interested in the project and initiated a preliminary study in 1976 to define the goals and methods of a possible project. The governing body of SITRA approved the idea in 1977 and reserved US $400 000 for a project lasting three years. The National Board of Health and the Finnish Hospital League were co-sponsors and together provided a further US $100 000. The leading role was assumed by SITRA, a neutral body in this delicate area.

SITRA's reputation and experience gave the project a very favourable image. A representative steering committee was seen as a prerequisite for a successful project. The project had a physician as its full-time leader, and an administrator, two nurse teachers and two secretaries. The project leader had both clinical and administrative experience and an international education in health planning.

Focus of the project

A limited number of relatively clear-cut and widespread disease entities were selected for the development of programmes. They were analysed very thoroughly keeping in mind both the process of developing care programmes and their practical implementation. The overall objective was

that the service system as a whole should be trained to understand the value of care programmes and be competent to make its own specific programmes at regional and even institutional level.

Care programmes rely on multidisciplinary expertise: medical, nursing, rehabilitative, etc. Careful attention should be devoted to ensuring wide participation throughout the drafting of the programme, especially in the early stages. A special questionnaire was constructed to elicit opinions about the small details that are important in practical work. Answers could not be given without reading the draft programme. The objective was to take all positive criticism into account and to familiarize the medical world with this approach in its early stages.

Because the project aims to change decision-making and attitudes, a continuous process is vital for success. Publicity as well as consultation with health professionals and other concerned groups was thoroughly planned. The programme was well written and clearly presented. The final programmes were presented as major achievements and publicized not only via professional meetings and periodicals but also through the general news media. Wide distribution was considered important. A special demonstration project on how to implement care programmes at the regional level was incorporated into the project.

Objectives of the project

The objectives of the project were defined as follows:

- to prepare model health care programmes for some common diseases and syndromes;
- to stimulate discussion on the preparation and use of health care programmes;
- to provide models and methods to hospital regions preparing regional health care programmes for the most important diseases;
- to act as an incentive for continuous development activity in health care;
- to increase consideration of the economic aspects and efficiency in health care;
- to develop methods of measuring the need for resources in national and regional plans of health care.

The objectives of health care programmes were understood to be:

- to standardize medical practice;
- to improve cooperation between institutions;

— to increase the safety of patient care;

— to aid the education of health care personnel;

— to act as a tool for improving cooperation between different groups of personnel and to clarify the division of labour between them.

In addition, it was stressed that the care programmes should be constructed within the limits of existing resources.

Administrative structure

A steering committee was set up, comprising 15 people representing a balance of formally responsible organizations and other major interest groups. It included the Assistant Secretary of State of the Ministry of Social Affairs and Health, two senior medical officers from the national health administration (the National Board of Health), and representatives of the Finnish Hospital League, of universities, and of professional associations. The representative of SITRA was the Chairman. In the three years that the project functioned, the steering committee had 21 meetings, documents were circulated in advance, and adequate time was reserved for discussions.

Selection of diseases/syndromes

The first major task for the steering committee was to select suitable diseases/syndromes on which the project should concentrate. Those selected had to cover different types and orientations of care (acute/long-term, medical/surgical, etc.). Furthermore, each disease/syndrome had to be important in terms of public health and economic consequences. After careful consideration, the following seven diseases/syndromes were chosen: stroke, fractured femoral neck, varicose veins, rheumatoid arthritis, asthma, backache, and gallstones.

The steering committee stressed that care programmes should cover both the care given in hospitals and ambulatory care in outpatient departments and primary health centres.

Preparation of the programmes

Each programme was prepared by a team consisting of specialized physicians, general practitioners, nurses and physiotherapists. The teams had four to eleven meetings, depending on the programme, but the major work was done outside these meetings. A specialist led each team and was responsible for writing the programme. The team for the stroke

programme, for example, consisted of five neurologists, two internists, one general practitioner, three nurses, and two physiotherapists.

To start with, representatives of the medical profession, hospital administrators, nursing officers, various trade unions of hospital personnel, etc. were interviewed by the project group. The motives were both to gain acceptance of the project by the relevant parties and to clarify the problems of health care.

Before the final instructions were given to the teams preparing the programmes, the project group analysed the current practices in the country. Three different approaches were used simultaneously.

1. Medical records were analysed to establish a relevant description of present practice. For each disease (programme), a random sample of 30 medical records from each of 6 central hospitals was drawn up and examined.

2. A large number of people working in hospitals were interviewed to assess and document their opinions on the advantages and shortcomings of the present practice.

3. An analysis was made of the Hospital Discharge Register. A cohort of discharged patients for each selected disease was followed. Data analysed included the number of hospital visits, the length of stay, the distribution by age and severity, and the distribution between different levels of hospitals. This Register is based on individual reports and covers all hospitals in Finland.

The results of these surveys were given to the programme teams as an outline of the current practice.

Consultation with the concerned groups

When the first draft of a programme was finished, it was sent to various health authorities and associations, and to about 200 doctors, nurses, physiotherapists, etc. for their evaluation. In each programme, feedback was received from about 100 people. The aim was to test the acceptability and applicability of the programmes, to get proposals for improving the contents and, last but not least, to "sell" the programme. On the basis of the comments, the final programme was completed. After publication, 2500–3500 copies of each programme were distributed free of charge to health centres and different types of hospital. About 150–200 invitations to an information meeting on each programme were mailed to representatives of the medical and nursing professions.

One of the basic purposes of the project was to promote the preparation of health care programmes at the regional level. To stimulate regional interest and activity in developing regional programmes, special guidelines concerning the organization and methods of implementation were prepared and published as part of the project. The guidelines are based on the experiences gained in the implementation experiment in the Turku University Central Hospital region.

During the project, a network of contact people, composed of senior specialists and nursing officers, was created and they were trained to act as links between the regional networks of hospitals and the Finnish Hospital League. They were asked to monitor the implementation and promote the development of health care programmes in their own regions.

In order to implement health care programmes produced by SITRA locally and to promote the development of care programmes in general, the following methods were used.

Meetings for regional consensus

The hospital regions arranged one-day meetings in their catchment areas, concerning one health care programme at a time. All service units functioning in the region were represented and the meetings were intended for medical, nursing and auxiliary personnel. The purpose of such meetings was to achieve a consensus on how the care of the disease/syndrome would be organized in the region.

Local working groups

Some regions established special working groups to promote the development of health care programmes.

Local modifications

Teams set up locally occasionally modified some programmes markedly.

Follow-up activities

The SITRA project achieved its immediate objectives and is now completed. The Finnish Hospital League will act as the national coordinating organ to monitor its long-term impact. A permanent project group has been established to support the regional teams on methodological issues and to keep a file on regional and local health care programmes and applications. The Finnish Hospital League will invite the original programme teams to meetings, where the need for revision will be considered at two- to three-year intervals.

Evaluation

The general reception of the project has been positive. The project group has been in regular contact with the central hospital regions. They have also participated in training meetings all over the country. The experiences gained so far are as follows:

— interest has been great, both as regards the programmes prepared and the need for developing health care in general;

— regional training meetings concerning the programmes for stroke and fractured femoral neck have been arranged in almost all regions;

— the preparation of regional agreements on health care practices (applications of the programmes) is in progress in many regions;

— the general impression is that the programmes have been successful in clarifying and improving cooperation and the division of labour between different health personnel groups and institutions.

The SITRA project also aimed at increasing consideration of the economic and efficiency aspects of health care and developing methods of estimating the resource requirements of national and regional plans. In fact, the prime motive for launching the project was to help attain better results with the available resources.

In the final stages of the SITRA project, a special working group (a so-called resource group) was appointed by the steering committee to develop methods and a general model of measuring the resource requirements and outcome (effectiveness) of care. The group consisted of two economists, three doctors, two planners and two nurses.

The group reviewed and discussed various approaches to measuring outcome (i.e. health). Not unexpectedly, they could not find any entirely satisfactory method of measuring health in a general way, independent of disease. The Group finally recommended an approach where health is measured with regard to 12 dimensions reflecting health and physiological and social functioning.[a] These dimensions are then combined into an overall index.

With regard to general principles, the group emphasized that in costing, the whole process of care has to be considered. Thus, defining the time horizon of a programme is of critical importance. For that purpose, three

[a] **Sintonen, H.** An approach to measuring and valuing health states. *Social science and medicine*, **15C**: 55–65 (1981).

types of programme were distinguished according to the disease in question: those providing "once-and-for-all" treatment, long-term treatment, and continuous treatment. In the third case, there is no limit to when the treatment can be regarded as having come to an end. Therefore, for evaluation purposes, some arbitrary time horizon has to be agreed upon.

Within the time horizon covered by programmes, not only do the costs of treating the disease within the health care system (in hospitals, clinics, etc.) have to be included, but the time used by the patients and the workload imposed on their relatives and other sectors of society (e.g. social services) also have to be costed and considered.

The group distinguished between what are referred to as the "pure cost" and the "organization-dependent cost" of a programme. One arrives at the former by costing, as such, the direct goods and services to the patient required by the programme. Organization-dependent costs are fixed, indirect costs that accrue according to the different types of organization in which the programme is implemented (such as hospitals). This distinction was considered useful when making comparisons between various hospitals and in drawing conclusions about the appropriate balance of care.

Whether the introduction of a programme constitutes an improvement in cost-effectiveness can only be decided on the basis of a comparison with the old practice. In the Finnish case, the chances of rigorous evaluation were lost to a great extent owing to the fact that by the time the resource group had finished its work, most of the programmes were already published, and efforts to get them adopted and implemented were well under way. Ideally, the resource group should have been established first to analyse the old practice and evaluate its cost-effectiveness before the introduction of the programme, and then repeat the exercise afterwards.

In spite of these difficulties, the Finnish Hospital League and the Ministry of Social Affairs and Health are planning together to pursue the evaluation of the impact of recommending a programme along two lines.

First of all, in a retrospective study of existing information systems, the Hospital Discharge Register will be used to find out whether there are any differences:

— in the number of hospital days or hospitalization periods per patient owing to a given disease;

— in the hospital case-mixes (i.e. in the proportion of patients with the disease);

— in the distribution of patients with the disease between various types of hospital or institution (in the balance of care);

— in mortality due to the disease within the same central hospital region, before and after the introduction of the programme for the disease.

The other line of investigation involves a prospective study. The development of the health status of patients admitted to hospital with a given disease will be followed using the measure of health outlined above, for say, a year in a region where a SITRA programme has been adopted and well implemented, as well as in some other region with a programme of its own where there is a different school of thought prevailing. At the same time, the costs of the programme will be recorded in considerable detail.

Annex 2

THE FINNISH MODEL HEALTH CARE PROGRAMME FOR STROKE — A GENERAL DESCRIPTION

Scope of the programme

The stroke programme covers all cerebrovascular disturbances, whether induced by cerebral ischaemia or arterial bleeding. The general design of the programme is process-oriented. It presents detailed principles for routine work, ranging from prevention to rehabilitation. The overall structure of the programme is as follows:

— definitions, pathogenesis and clinical picture;

— diagnosis and differential diagnosis;

— treatment by type of disease (transient ischaemic attack, cerebral infarction and bleeding, subarachnoidal bleeding).

Special attention is paid to the following points:

— the admission of the patient to the health care system; the referral system;

— the purposeful selection of patients for different types of institution;

— the objectives and general principles of care;

— the medical treatment;

— the nursing care;

— physiotherapy and rehabilitation;

— the instructions for the patients and their relatives;

— the provision of social security.

Justification

In Finland, about 10 000 adults annually experience cerebrovascular disturbances; about 5500 of them die. Stroke ranks third after coronary heart disease and malignant tumours in the Finnish mortality statistics. Approximately 800 000 patient-hospital days are taken up by patients with cerebrovascular disturbances. Additionally, one million patient days are spent in the nursing homes of local authorities owing to the late effects of strokes.

The heavy burden on the health services system was the principal reason for choosing stroke for programme activities. It is also likely that better end-results could be achieved by more active and effective treatment and care. Furthermore, it is known that patients are not being treated at the appropriate level of hospitals or other institutions.

Focus of the programme

Although the whole continuum of how to examine and treat a stroke patient was included in the programme, special attention was devoted to those phases of care that could be markedly improved.

Referrals and the correct place for treatment

With a problem such as stroke, the need for technical care varies from case to case. The programme gives criteria that can be relied on when selecting patients for conservative treatment and for referral for specialist neurological examination. The decision-making process is presented visually.

Early active rehabilitation and nursing care

The process of physiotherapy and rehabilitation is described very carefully, as are the roles of nurses and physiotherapists in it. Special emphasis is given to the patient's own active cooperation to diminish his later dependency ("Do not assist the patient in activities that he can manage himself"). The programme contains many illustrations of proper physiotherapy.

Normally, the proper place for a stroke patient is a health centre or intermediate hospital. This applies especially to elderly patients. If the clinical picture or the progress of disease suggests that further examination might indicate, for example, operative treatment, a central hospital would be the proper institution.

Implementation trial

To test the feasibility of the programme in practice and to gain experience for future implementation, an experiment was arranged in the hospital region of Turku in south-western Finland. The health care network in the region consists of a university central hospital, several intermediate hospitals and numerous smaller local hospitals which in Finland are part of health centres. The region has a population of 420 000.

The experiment was started by carrying out a survey of patients staying at various health care institutions because of stroke or its sequelae. The

following items were recorded: the number of patients at different levels; the duration of hospital-stay at different levels; and the dependency of patients.

An advisory committee consisting of 12 members was set up to follow and supervise the experiment. The members represented all the parties concerned: different types of institution and groups of personnel. The implementation trial in the Turku region proceeded as follows.

Chief doctors and head nurses of the specialty in question were contacted to get their opinion and acceptance of the tentative programme. Seminars for the chief doctors and head nurses of all health centres in the region were then arranged. In these meetings, current practices, especially the referral system, were discussed in detail. On the basis of the current practices and the proposals for improvements made in these seminars, an application scheme of the stroke programme for the region was prepared. It included a specified referral system for each health centre.

The programme was then extensively distributed to all hospitals and health centres in the region. One-day training meetings dealing with the main principles of the programme were arranged in many hospitals and health centres. The main responsibility for training lay with the representatives of the central hospitals and intermediate hospitals. The personnel attending these training meetings (consultants, head nurses, ward sisters, doctors and nurses in ambulatory care) were encouraged to discuss the programme in their own training meetings, in which all relevant personnel groups participated.

The project leader of SITRA participated personally in the trial. When the results were presented to the steering committee, it was concluded that building active cooperation between different service units is very important. The care programme was welcomed, and the participants discussed the programme with considerable interest. These experiences were taken into account when the recommended guidelines were documented for publication.

Annex 3

THE MINI-FINLAND STUDY — BASELINE EPIDEMIOLOGICAL INFORMATION FOR A MODEL HEALTH CARE PROGRAMME

The Mini-Finland Study data are findings based on a two-stage cluster sample of 8000 adults aged 30 or over, representative of all Finnish adults of this age. A health interview in the subjects' homes was followed a few weeks later by a health examination arranged using mobile clinic units. Over 95% of the people in the samples were interviewed and the participation rate in the health examination was 90%.

The health examination concentrated on several symptoms including musculoskeletal pain symptoms, such as back pain and sciatica. A diagnosis of back disorders was made, and both the met and unmet need for care, the consequences in terms of work and other limitations and disabilities were estimated.

In the interview, over half the adults (56% of men, 54% of women) reported having experienced back pain at least six times, and over 15% had had back pain that lasted at least three months. One third had experienced at least one episode of back pain during the past month. Almost one third reported a back disorder diagnosed at one time or another by a doctor, one quarter had used medication for it and 7% had been treated in hospital. Some 7–8% were currently being treated for a back disorder.

The occurrence of symptoms and disease increases with age, reaches its peak in middle age and diminishes thereafter. The decline after middle age is undoubtedly related to the lack of physical job stresses after retirement but perhaps also to changes in the musculoskeletal system that occur with age.

In the health examination, doctors made a diagnosis of any back disease in 16% of adults aged 30 or over; 7% were judged to be suffering from a definite back disorder and 9–10% from a possible back disorder. The health examination suggested that back disorders were even more common than the estimated 7% based on the interview results.

There were no marked sex differences in the occurrence of symptoms, but the cumulative incidence of conditions requiring treatment in primary care and hospitals seemed to be higher in men.

According to interview data, 20% of women and 30% of men aged 30–59 had at least once during the previous five years been unable to perform their usual tasks because of back pain. This limitation had lasted for at least one month and 2.5% of women and 4.3% of men had changed

their jobs because of back pain. About 15% of all invalidity pensions in 1980 and 1981 were due to back disorders.

Occupational variation was clear. Groups in physically demanding jobs, as well as in jobs into which chronically ill people had probably drifted, showed 1.6 times higher prevalence rates for back disorders than those in low-risk occupations. These high-risk groups consisted of those employed in agriculture, forestry, industry and the services, as well as housewives. The functional and social consequences of back disorders were also more common in these groups.

A survey such as this also shows that a considerable proportion of the need for care is unmet. Furthermore, the use of services and the proportion of need that is met vary by geographic region, age, sex and occupational group. Much of the variation in use is not due to a corresponding variation in need.

A fairly small proportion of all back disorder patients are ever in need of specialized hospital care, although it has an important role to play. Most of the burden within the health services lies with primary care. Both experience and the above data demonstrate the very high occurrence of back pain. Most episodes of back pain apparently resolve spontaneously or after the application of various means of self-care.

It is also of interest, when discussing an MHCP for low back pain, that patients with this disorder often suffer simultaneously from other chronic diseases. Psychological symptoms and social problems seem to be quite common among patients with chronic low back pain.

Annex 4

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[a] Participation expenses not paid by WHO.

RESUME

Introduction

Cette réunion du groupe de travail constitue la première réalisation majeure, sous l'égide du Bureau régional de l'OMS pour l'Europe, de la nouvelle activité relative aux programmes modèles de soins de santé et de garantie de la qualité des services de santé. Dix-sept conseillers temporaires ont participé à la réunion qui leur a permis de mettre en commun leur expérience du développement des programmes modèles de soins de santé, de l'administration d'établissements de soins de santé, de la planification sanitaire nationale et des recherches économiques et sanitaires.

Les programmes modèles de soins de santé sont des directives ou recommandations écrites, en fait une synthèse des mesures préventives, diagnostiques et thérapeutiques, du processus de soins infirmiers, et des actions en vue de l'observation, de la réadaptation, qui peuvent entrer dans les soins dispensés aux patients atteints de certaines maladies ou affectés par certains problèmes de santé. Dans divers Etats, des services de santé ont conjointement élaboré et divulgué de telles directives. Dans d'autres pays, alors même qu'il n'existe pas de recommandations explicites, on peut néanmoins disposer d'un ensemble de procédures prédominantes en matière de soins de santé. L'une des raisons, que l'on peut avancer de l'intérêt que suscitent de plus en plus ces directives, réside dans la complexité sans cesse croissante et dans la nature interdisciplinaire des soins de santé : choisir, imposer, programmer et coordonner les combinaisons de procédures les plus économiques et qui conviennent le mieux, dépasse souvent la compétence d'un dispensateur de soins de santé isolé, qu'il s'agisse d'un médecin, d'une infirmière ou d'un travailleur social. Un tel programme sera donc de nature à faciliter leur travail en donnant une indication de la place qui peut leur être dévolue dans le processus de la prestation de soins. De plus, l'évolution du tableau des maladies permet de recourir à de telles directives : le traitement des maladies chroniques n'appelle pas nécessairement des décisions immédiates; les dispensateurs de soins de santé ont le temps de se référer aux modèles normalisés recommandés pour les soins et d'appliquer à la prise de décisions des règles préétablies.

Lors du séminaire, tenu à Munich du 1er au 4 décembre 1980 sur les avantages, du point de vue coût-efficacité, d'une normalisation des soins de longue durée, les participants avaient soulevé la question suivante : «Est-il rentable (en termes de rapport coût-efficacité) de recommander des types

de soins normalisés ?» Compte tenu de leurs conclusions, le présent groupe de travail a posé la question suivante : «Comment élaborer des programmes modèles de soins de santé et comment les mettre en œuvre ?», si ces programmes constituent un moyen de déterminer le meilleur dosage possible de soins de santé pour chaque patient.

Les principes identifiés au cours de la première phase ont alors été appliqués à un problème de santé particulier, celui des douleurs sacro-lombaires, et un certain nombre de centres collaborateurs ont accepté d'élaborer un programme de soins à cet effet.

Sujets débattus

Définition des programmes modèles de soins de santé; leur justification

Les questions à l'étude portent sur le coût, la qualité et l'intégration des soins de santé. La justification fondamentale de ces programmes réside dans la possibilité d'améliorer la qualité des soins et d'intégrer leurs diverses composantes. La notion de coût ne suffit évidemment pas en soi à motiver un choix.

Expériences nationales

Des rapports ont été présentés sur la situation en Finlande, en Suède et en URSS. Les deux premiers de ces pays semblent pouvoir se prévaloir d'une expérience particulièrement ancienne en matière d'élaboration de programmes de modèles de soins de santé, à l'échelon national et local. Plusieurs programmes ont été mis à l'épreuve ces dernières années, avec des résultats prometteurs. Dans ces pays, ils trouvent leur application surtout pour les douleurs lombaires basses, l'hypertension, le diabète, le cancer du sein, les attaques d'apoplexie et les fractures de la hanche.

Identification des secteurs pour lesquels l'utilisation de programmes modèles de santé est possible; critères applicables à leur choix

Les participants sont convenus qu'un problème de santé doit à cette fin avoir des incidences à la fois économiques et sociales ou avoir été sérieusement négligé. Il a été également admis que les professionnels concernés doivent témoigner un intérêt pour ces programmes.

Conditions préalables à l'élaboration de programmes modèles valables pour les soins de santé

Il a été décidé qu'un programme modèle pour les douleurs lombaires basses devait être conçu comme suit :

Connaissances de base. Quel est le problème ? Quelle est son importance et, le cas échéant, pourquoi ? La qualité des soins est-elle insuffisante ?

Peut-elle être améliorée ? Le coût peut-il être modifié ? Quelle est la durée de la période de planification requise pour qu'un programme soit élaboré ? Des ressources complémentaires seront-elles nécessaires ?

Buts/objectifs. Le traitement peut-il être amélioré dans les limites des ressources existantes *ou bien* faut-il mettre davantage l'accent sur la prévention et l'auto-prise en charge ?

Stratégies. Quelles stratégies devraient être utilisées pour améliorer la prévention, l'auto-prise en charge ou la thérapie ?

Mesures préventives. Description des options existantes : comment, où et quand ?

Mesures diagnostiques. Problèmes de classification, méthodes et actes et diagnostic à divers niveaux. Avantages et inconvénients de différentes procédures.

Mesures thérapeutiques. Comment, où et quand ?

Organisation. Aspects organisationnels de la prévention, du diagnostic et du traitement.

Aspects sociaux. Description de la composante sociale, socio-économique et psychologique des notions de travail, de loisirs, d'assurance, de famille. Les professionnels devraient être incités à envisager des solutions non cliniques.

Education et recherche, et autres mesures de soutien. Expliquer la nécessité de recherches plus approfondies sur le rapport coût-efficacité pour les soins non professionnels et celle d'une meilleure connaissance de l'étiologie de la nature des douleurs sacro-lombaires. Les programmes modèles de soins de santé devraient stimuler la recherche et l'éducation des consommateurs.

Evaluation. Il faudrait s'efforcer de mettre en évidence les effets du programme eu égard à ces objectifs.

Groupes cibles et secteurs d'application des programmes modèles de soins de santé. L'adoption et l'exécution d'un programme relatif aux douleurs sacro-lombaires devraient mobiliser tous les groupes et secteurs concernés : écoles et enseignants, médecine du travail, consommateurs et dispensateurs de soins.

L'élaboration d'un programme à cet effet serait fondée sur les recommandations générales qui seront exposées dans le rapport final du groupe de travail et comportera les étapes suivantes :

- rédaction d'un programme modèle national de soins de santé (destiné à être utilisé au niveau national ou local dans différents pays), selon les recommandations;

– mise en œuvre du programme en fonction des problèmes particuliers des pays participants;

– enregistrement de l'expérience acquise et évaluation des résultats obtenus.

Recommandations

Le groupe de travail recommande l'élaboration, à l'échelle pilote, d'un programme-modèle de soins de santé pour les douleurs lombaires basses dans des pays dotés de systèmes sanitaires différents. Ce programme devrait considérer tout particulièrement la gestion des douleurs lombaires basses dans le cadre des soins de santé primaires.

ZUSAMMENFASSUNG

Einleitung

Diese Arbeitsgruppentagung stellte im Rahmen des neuen europäischen Programms für Gesundheitsversorgungsmodelle und Qualitätssicherung der Gesundheitsdienste die erste größere Tätigkeit unter der Schirmherrschaft des WGO-Regionalbüros dar. An der Tagung nahmen 17 Berater auf Zeit teil, die folgende Gebiete vertraten: Erstellung von Programmen für Gesundheitsversorgungsmodelle, Verwaltung von Einrichtungen des Gesundheitsbetreuungswesens, Planung des staatlichen Gesundheitswesens, Wirtschaft und Strukturforschung im Gesundheitswesen.

Programme zur Erstellung von Gesundheitsversorgungsmodellen sind schriftliche Leitlinien oder Empfehlungen für einen Verbund von präventiven, diagnostischen, therapeutischen, pflegerischen, überwachungsmäßigen und rehabilitativen Verfahren zur Betreuung von Patienten mit bestimmten Krankheiten bzw. Gesundheitsproblemen. In einer Reihe von Ländern haben sich Gesundheitsbehörden zusammengeschlossen und Leitlinien dieser Art ausgearbeitet und verbreitet. In anderen Ländern existieren keine ausdrücklichen Empfehlungen dieser Art, doch haben sich u.U. bestimmte Verfahren herauskristallisiert. Ein Grund für das zunehmende Interesse an solchen Leitlinien ist in der Tatsache zu suchen, daß die medizinische Betreuung komplizierter wird und in größerem Umfang einen interdisziplinären Einsatz erfordert: die Auswahl, Ordinierung, zeitliche Planung und Koordinierung einer bedarfsgerechten und nutzbringenden Verfahrenskombination übersteigen oft die Fähigkeiten eines einzelnen Leistungserbringers, sei er Arzt, Krankenschwester oder Sozialarbeiter. Die Arbeit dieses Personenkreises würde deshalb durch ein Programm erleichtert, das ihre eventuelle Rolle im Pflegeprozeß andeutet. Gleichzeitig ist die praktische Anwendung solcher Leitlinien möglich geworden, da sich das Morbiditätsmuster verändert hat: Die Behandlung chronischer Krankheiten erfordert in der Regel nicht einen sofortigen Entschluß; die Erbringer der gesundheitlichen Leistung haben genügend Zeit, um die empfohlenen Standardbetreuungsformen zu untersuchen und vorgegebene Entscheidungsmaßstäbe anzuwenden.

Auf einem früheren Arbeitsseminar der WGO über „Kostenwirksamkeit von Empfehlungen für Standardformen der Langzeitbetreuung" ist folgende Frage angeschnitten worden: „Lohnt es sich (kostenwirksamkeitsmäßig), Standardbetreuungsformen vorzuschlagen?" Von den Erwägungen des vorgenannten Arbeitsseminars ausgehend, stellte man sich auf dieser Arbeitstagung

die Frage: „Wie sind Programme zur Ausarbeitung von Gesundheitsversorgungsmodellen aufzuziehen und wie können sie durchgeführt werden?" Solche Programme sollen grundsätzlich dem Zweck dienen, die zweckmäßigste Kombination der Gesundheitsdienste für den einzelnen Patienten zu ermitteln.

Die im ersten Tagungsabschnitt ermittelten Grundsätze wurden dann auf ein bestimmtes Gesundheitsproblem angewandt, nämlich Kreuzschmerzen. Mehrere Kollaborationszentren haben sich bereit erklärt, ein Betreuungsprogramm für dieses Leiden zu entwickeln.

Besprechungspunkte

Definition und Begründung für die Ausarbeitung eines Programms zur Erstellung von Gesundheitsversorgungsmodellen

Hierunter fielen Erörterungen über Kosten, Qualität und Integrierung. Die diesen Faktoren zugrunde liegende Motivation ist die Ermöglichung einer besseren Betreuungsqualität und die Integrierung verschiedener Betreuungskomponenten. Man war sich darüber einig, daß die Kostenfrage als solche als Motivation nicht ausreicht.

Erfahrung der Einzelstaaten

Hierzu berichteten Finnland, Schweden und die UdSSR. Finnland und Schweden haben bei der Erstellung von Modellprogrammen für die Gesundheitsversorgung sowohl auf übernationaler als auch örtlicher Ebene anscheinend die meiste Erfahrung. In den letzten Jahren sind mehrere Programme erprobt worden und haben zu erfolgversprechenden Ergebnissen geführt. Sie werden in diesen Ländern besonders für Kreuzschmerzen, Hypertonie, Diabetes, Brustkrebs, Schlaganfall und Bruch des Oberschenkelhalsknochens durchgeführt.

Feststellung von Bereichen, die sich für die Anwendung von Gesundheitsversorgungsmodellen eignen, und diesbezügliche Auswahlkriterien

Man kam zu der einheitlichen Auffassung, daß als Voraussetzung für ein Modellprogramm die Krankheit sowohl wirtschaftlich als auch sozial wichtig oder aber ernsthaft vernachlässigt worden sein soll. Außerdem muß seitens der betroffenen Fachkräfte ein Interesse an solchen Programmen bestehen.

Voraussetzungen für die Ausarbeitung von Modellprogrammen der Gesundheitsbetreuung

Nach Meinung der Teilnehmer sollte ein Modellprogramm für Kreuzschmerzen folgende Komponenten berücksichtigen:

Allgemeines: Worin besteht das Problem? Ist das Problem von Bedeutung - wenn ja, warum? Ist die Betreuungsqualität unzureichend? Kann die

Betreuungsqualität verbessert werden? Lassen sich auf der Kostenseite Änderungen erzielen? Wie lange dauert die Planungsphase zur Erstellung eines Programms? Werden zusätzliche Ressourcen benötigt?

Allgemeinziele: Läßt sich die Behandlung mit Hilfe der vorhandenen Ressourcen verbessern *oder* sollte der Prävention und Selbstbetreuung mehr Beachtung geschenkt werden?

Strategien: Welche Strategien sind für eine Verbesserung von Prävention, Selbstbetreuung oder Behandlung anzuwenden?

Präventivmaßnahmen: Beschreibung der vorhandenen Möglichkeiten: wie, wann und wo?

Diagnostische Maßnahmen: Klassifizierungsprobleme, diagnostische Methoden und Verfahren auf verschiedenen Ebenen. Pro und Kontra der verschiedenen Verfahren.

Therapeutische Maßnahmen: wie, wo und wann?

Organisation: organisatorische Aspekte der Prävention, Diagnose und Behandlung.

Soziale Aspekte: Beschreibung der sozialen, sozialökonomischen und psychologischen Faktoren in bezug auf Arbeit, Freizeit, Versicherungsverhältnisse, Familienverhältnisse. Anhalten der Fachkräfte, auch nichtklinische Lösungsmöglichkeiten ins Auge zu fassen.

Aufklärung und Forschung sowie andere Hilfsmaßnahmen: Darlegung des Bedarfs an einer weiteren Erforschung der Kostenwirksamkeit einer Alternativbetreuung und an größerem Erfahrungswissen über Ätiologie sowie Art der Kreuzschmerzen. Die Programme zur Erstellung von Gesundheitsversorgungsmodellen sollten auf Forschung und Aufklärung der Leistungsempfänger stimulierend wirken.

Auswertung: Man sollte den Versuch unternehmen, die Auswirkungen des Programms im Hinblick auf die angestrebten Ziele zu untersuchen.

Zielgruppen und -gebiete für Modellprogramme der Gesundheitsversorgung: Bei der Einführung und Durchführung eines Modellprogramms für Kreuzschmerzen sollten nicht nur alle direkt betroffenen Gruppen, sondern auch Schulen, Lehrer, Arbeitsmedizin, Leistungsempfänger und Leistungsanbieter mit einbezogen werden.

Die Durchführung eines Programms für Kreuzschmerzen würde auf den Empfehlungen basieren, die im Schlußbericht der Arbeitstagung enthalten sind und folgende Phasen umfassen:

- schriftliche Ausarbeitung eines einzelstaatlichen Gesundheitsversorgungsmodells zur Anwendung auf überregionaler oder örtlicher Ebene in verschiedenen Ländern, wobei die Empfehlungen zu beachten sind;
- Durchführung dieses Programms unter Berücksichtigung der spezifischen Problematik der jeweils teilnehmenden Länder;
- Aufzeichnung der Erfahrungen und Auswertung der erzielten Ergebnisse.

Empfehlungen

Die Arbeitsgruppe empfahl die Ausarbeitung eines Pilotmodells zur Gesundheitsbetreuung in Fällen von Kreuzschmerzen, und zwar in mehreren Ländern mit verschiedenen Gesundheitsbetreuungssystemen. Bei diesem Programm ist besonders die Bearbeitung der Kreuzschmerzen auf der Stufe der primären Gesundheitsbetreuung zu beachten.

РЕЗЮМЕ

Введение

Данная Рабочая группа стала первым важным мероприятием в рамках новой программы Европейского регионального бюро ВОЗ "Модель организации медико-санитарного обслуживания и обеспечения его качества". В совещании приняли участие семнадцать временных советников: специалисты по моделям медико-санитарного обслуживания, представители учреждений здравоохранения, национальных органов планирования и экономического обеспечения здравоохранения, работники, занимающиеся вопросами изучения деятельности служб здравоохранения.

Программы по моделям медико-санитарного обслуживания содержат рекомендации относительно организации комплексных мер по профилактике, диагностике, лечению, сестринскому обслуживанию, мониторингу и реабилитации при оказании помощи пациентам, страдающим отдельными заболеваниями или нарушениями здоровья. В ряде стран органы здравоохранения подготовили и выпустили руководящие указания, подобные тем, которые приводятся в рассматриваемых программах. В отдельных странах, где подобных указаний нет, зачастую в практике используются другие процедуры, определяющие организацию медико-санитарной помощи. Одна из причин того, что к указаниям такого рода проявляется все больший интерес, заключается в непрерывно усложняющемся междисциплинарном характере медицинской помощи. Подбор, организация, планирование и координация наиболее рациональных и выгодных комбинаций процедур, - все эти вопросы не может подчас решить представитель какой-либо одной медицинской специальности, будь то врач, медицинская сестра или работник социальных служб. Их задачу можно облегчить, разработав программу, в которой указывалась бы их возможная роль в процессе медико-санитарного обслуживания. К тому

же, изменения в структуре заболеваемости позволяют прибегнуть к использованию таких руководящих указаний: при лечении хронических болезней, как правило, нет необходимости в принятии срочных решений; лица, предоставляющие медицинскую помощь, имеют в своем распоряжении достаточно времени для того, чтобы изучить рекомендованные стандартные модели обслуживания и применить на практике разработанные правила принятия решений.

На состоявшемся ранее Рабочем совещании ВОЗ по стоимости/эффективности применения стандартных моделей организации долгосрочной помощи был поднят вопрос: "Целесообразно ли (в экономическом плане) рекомендовать использование стандартных моделей организации помощи?" Используя материалы дискуссии, проходившей на вышеупомянутом Рабочем совещании, данная Рабочая группа в первую очередь сосредоточила внимание на вопросе: "Каким образом следует разработать программы по моделям медико-санитарного обслуживания и как их следует осуществлять?"; при этом учитывалось, что такие программы дают возможность подбора наиболее целесообразных комбинаций мер, связанных с организацией медицинской помощи отдельным пациентам.

Принципы, которые были определены на данном этапе, в последующем были применены при решении конкретной медицинской проблемы, а именно: проблемы лечения болей в пояснице. В этой связи ряд сотрудничающих центров решил разработать конкретную программу оказания соответствующей медицинской помощи.

Темы

Определение содержания программы по модели медико-санитарного обслуживания и обоснование необходимости ее разработки: данная тема включала в себя вопросы стоимости, качества и интеграции лечебно-профилактических мер. Обсуждение этих вопросов имело целью определить пути повышения качества обслуживания и развития интеграции различных его компонентов. По общему мнению, вопрос стоимости нельзя рассматривать в качестве весомого фактора per se.

Представление докладов о деятельности в странах. Были рассмотрены доклады о работе, проводимой в Советском Союзе, Финляндии и Швеции. Представляется, что Финляндия и Швеция располагают наибольшим опытом разработки программ по моделям медико-санитарного обслуживания как на общенациональном, так и на местном уровнях. В последние несколько лет прошли апробацию некоторые программы, результаты осуществления которых можно оценить как обнадеживающие. В указанных странах в рамках таких программ главным образом решаются проблемы лечения болей в пояснице, гипертонической болезни, диабета, рака молочной железы, паралича и переломов бедра.

Определение областей применения программ по моделям медико-санитарного обслуживания и критерии их отбора. Участники совещания выразили мнение, что программы следует разрабатывать для борьбы с болезнями, которые чреваты социально-экономическими последствиями или которым в прошлом не уделялось достаточно внимания. Совещание считает, что специалистам в соответствующих областях следует проявить интерес к таким программам.

Требования, обеспечивающие успешную разработку моделей программ медико-санитарного обслуживания. Участники совещания согласились с тем, что модель программы лечения болей в пояснице должна включать следующие компоненты:

1. Исходные сведения

В чем состоит суть проблемы? Важна ли эта проблема, если да, то почему? Является ли удовлетворительным качество предоставляемого обслуживания? Можно ли улучшить его качество? Можно ли сократить расходы на него? Каким продолжительным должен быть период планирования при разработке программы? Могут ли потребоваться дополнительные ресурсы?

2. Цели/задачи

Можно ли улучшить лечение, используя имеющиеся ресурсы, или следует обратить больше внимания на вопросы профилактики и оказания самопомощи?

3. Стратегии

Какие стратегии следует использовать в целях совершенствования профилактики, самопомощи или лечения.

4. Профилактические меры

Описание существующих альтернатив: как, где и когда?

5. Диагностические меры

Проблемы классификации, диагностические методы и процедуры на различных уровнях. Доводы в поддержку и против различных процедур.

6. Терапевтические меры

Как, где и когда?

7. Организация

Организационные аспекты профилактики, диагностики и лечения.

8. Социальные аспекты

Описание социальных, социально-экономических и психологических факторов, связанных с работой, досугом, социальным обеспечением, семьей. Поощрять специалистов на поиски неклинических решений.

9. Санитарное просвещение, научные исследования и другие вспомогательные мероприятия

Разъяснение необходимости дальнейшего изучения вопросов экономической эффективности альтернативной помощи и расширения знаний об этиологии и природе болей в пояснице. Модели программ медико-санитарного обслуживания должны содействовать проведению исследований и санитарному просвещению населения.

10. Оценка

Следует попытаться продемонстрировать эффективность программы в плане реализации поставленных целей.

11. Целевые группы и области применения моделей программ медико-санитарного обслуживания

При внедрении и реализации программы лечения болей в пояснице следует задействовать все соответствующие группы и области, такие, как, например, школьные учителя и школы, производственная медицина, лица, предоставляющие и получающие помощь.

При разработке программы лечения болей в пояснице следует исходить из общих рекомендаций, изложенных в окончательном варианте отчета о совещании данной Рабочей группы. Процесс разработки программы включает следующие этапы:

- составление модели национальной программы медико-санитарного обслуживания для ее использования на общенациональном или местном уровне в различных странах с учетом подготовленных рекомендаций;

- реализация данной программы с учетом конкретных проблем, существующих в странах-участницах;

- регистрация получаемой информации и оценка достигнутых результатов.

Рекомендации

Участники Рабочей группы рекомендуют разработать опытную модель программы медико-санитарной помощи при болях в пояснице в странах с различными системами медико-санитарной помощи. В этой программе особое внимание должно быть уделено решению указанной проблемы в рамках системы первичной медико-санитарной помощи.

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